

# STATE OF MAINE

## BOARD OF ALCOHOL AND DRUG COUNSELORS

### APPLICATION FOR CERTIFIED CLINICAL SUPERVISOR (CCS) EXAMINATION



Department of Professional and Financial Regulation

Office of Licensing and Registration  
35 State House Station  
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689  
TTY/HEARING IMPAIRED 1-888-577-6690  
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine

Email: [voni.a.eames@maine.gov](mailto:voni.a.eames@maine.gov)

APPLICATION INSTRUCTIONS  
CERTIFIED CLINICAL SUPERVISORS

**All applicants must complete the following:**

1. Complete and sign the application.
2. Submit a copy of birth certificate, driver's license, or passport.
3. Submit an official transcript and proof of 30 hours of didactic training in clinical supervision.
4. Submit verification from every state in which you hold or have ever held any type license or credential to practice alcohol and drug counseling. This is also required if you are applying for a CCS as a practitioner with another type of mental health practice license.
5. Submit a copy of driving record from the Maine Department of Motor Vehicles (or appropriate agency if you are from another state).
6. Submit \$110.00 for examination candidates only - ( \$95.00 CCS examination fee and \$15.00 Criminal record history check fee) –  
Make checks payable to Treasurer, State of Maine. If paying by credit card, please submit the enclosed authorization form with your application.

**The following additional requirements must be submitted:**

**If you are a LADC:**

- Valid Maine Licensed Alcohol and Drug Counselor
- High school diploma or equivalent – 4,000 hours clinically supervised work experience;  
OR  
Associates or Bachelors degree – 2,000 hours clinically supervised work experience;  
OR  
Master's degree – 1,000 hours clinically supervised work experience.

**If you are a psychologist, physician, registered clinical nurse specialist, clinical professional counselor or clinical social worker who is licensed in Maine:**

- Valid Maine Professional License
- 1,000 hours of practice in alcohol and drug counseling

**If you are a licensed social worker, licensed professional counselor or other mental health practitioner:**

- Valid Maine Professional License
- 2,000 hours of practice in alcohol and drug counseling

**NOTE:** This is an abbreviated checklist and does not replace the requirements outlined in the Alcohol and Drug Counseling Laws and Rules. Please review them carefully for more detailed and clarifying information.

## Examination Dates for

License Category Examinations	Date of Exam	Deadline for application filing with the Board Office
All levels: CADC,LADC, and CCS	03/10/2006	01/25/2006
All levels	06/09/2006	04/27/2006
All levels	09/08/2006	07/27/2006
All levels	12/08/2006	10/26/2006

The Board of Alcohol and Drug Counselors requires that all supporting documents and fees be submitted with the filing of your application. Your application will be considered incomplete and will be returned if supporting documents and or fee are omitted. Documents that have been modified or altered in any way will not be accepted.



STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BOARD OF ALCOHOL AND DRUG COUNSELORS  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

Direct Tel: (207) 624-8689 Receptionist: (207) 624-8603  
FAX: (207) 624-8637 - TTY/ Hearing Impaired: 1-888-577-6690

JOHN ELIAS BALDACCI  
GOVERNOR

ANNE L. HEAD  
DIRECTOR

**APPLICATION FOR Certified Clinical Supervisor**

**Check One:**

☐ Application by examination (\$110.00)

**Check one that you are applying by:**

- ☐ Current LADC License number: \_\_\_\_\_ expiration date: \_\_\_\_\_
- ☐ Current psychologist, physician, registered clinical nurse specialist, clinical professional counselor or clinical social worker who is licensed in Maine  
License number: \_\_\_\_\_ expiration date: \_\_\_\_\_
- ☐ Current Licensed social worker, licensed professional counselor  
License number: \_\_\_\_\_ expiration date: \_\_\_\_\_

(1447) Examination Fee:	\$ 95.00
(2619) Criminal History Record Check Fee:	\$ 15.00 (non refundable)
Total	\$110.00

**Please Make Check Payable to Treasurer, State of Maine**

**Name(First, Middle, Last):**

**Any other names used:**

**Contact Address:**

**City:**

**State:**

**Zip Code:**

**County:**

**Telephone #:**

**Social Security #:**

**Date of Birth:**

**EDUCATION:**

NAME OF SCHOOL: \_\_\_\_\_

DEGREE AWARDED: \_\_\_\_\_ YEAR AWARDED: \_\_\_\_\_

30 HOUR OF DIDACTIC TRAINING IN CLINICAL SUPERVISION COMPLETED ON:

Note: certificate of attendance must be submitted

Including Maine, list each state or any other jurisdiction in which you hold or have ever held any type of professional credential or license

<u>State</u>	<u>License Type</u>	<u>License Number</u>	<u>Expiration date</u>

**ATTACH A SEPARATE SHEET IF NECESSARY**

\*\* You must also send the enclosed **Verification of Licensure** form to any other credentialing or licensing body where you hold or have held a license or credential, please follow directions on the form.

Check appropriate response to the questions. Any **YES** response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

**HAVE YOU EVER:**

1. Been convicted of any criminal offense (including motor vehicle offenses, but not including minor traffic or parking violations)? ☐ YES ☐ NO  
(If YES, please attach a detailed explanation and provide a copy of the court judgment/disposition.)
2. Had any state or territory EVER deny your application for any type of professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)?  
☐ YES ☐ NO
3. Received a sanction from Medicare or from a state Medicaid program?  
☐ YES ☐ NO
4. Had hospital or similar health care institution privileges ever been denied or which had previously been granted to you suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review? ☐ YES ☐ NO ☐ N/A

5. Had a judgment alleging malpractice liability, a claim settlement by negotiation, arbitration or judgment by a court in a claim of medical malpractice liability in which you are/were named as a defendant with any degree of liability including "nuisance" suits and including settlements made by your insurance company/representatives without your express consent? ☐ YES ☐ NO

#### **Notice regarding Social Security Number Disclosure**

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

#### **Notice regarding Public Information**

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

#### **Affirmation**

I hereby certify that all of the information given herein is true and complete to the best of my knowledge and belief.

I understand that falsification of any portion of this application may result in my being denied licensure, or revocation of same, upon discovery.

**By submitting this application I understand that the Board of Alcohol and Drug Counselors will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension, or revocation of my license if this information is found to be false.**

## AFFIDAVIT/DISCIPLINARY RECORD

**By signing this application, I acknowledge that I have read, understand, and agree to uphold the Alcohol and Drug Counselor Code of Ethics as it appears in the Rules of the Board and that I have been notified that my name may be reported to various disciplinary data banks if I am sanctioned by the Maine State Board of Alcohol and Drug Counselors for violating the Board's Laws and/or Rules.**

The Board of Alcohol and Drug Counselors requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

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**Signature of Applicant**

**Date**

**VERIFICATION FOR LADC  
OF CLINICALLY SUPERVISED EXPERIENCE**

<b><i>Name of Applicant:</i></b>		
<b><i>Address:</i></b>		
<b><i>City:</i></b>	<b><i>State:</i></b>	<b><i>Zip Code:</i></b>
<b><i>Applicants Job Title:</i></b>		<b><i>Telephone #:</i></b>
<b><i>The following section is to be completed by employer or supervisor only</i></b>		
<b><i>Name of Agency:</i></b>		
<b><i>Dates of Employment:</i></b>  <b><i>From:</i></b> _____ <b><i>To:</i></b> _____  <b><i>From:</i></b> _____ <b><i>To:</i></b> _____		
<b><i>Number of hours of clinically supervised work experience:</i></b>		
<b>I, the employer or supervisor, of the above named applicant is certifying the information provided on this form is verifiable, factual and accurate.</b>		
<b>Signature:</b> _____ <b>Date:</b> _____		

**TO SUPERVISOR COMPLETING THIS FORM:**

**THIS FORM IS TO BE RETURNED DIRECTLY TO THE APPLICANT NOT TO THE  
BOARD OF ALCOHOL AND DRUG COUNSELORS**

**VERIFICATION FOR OTHER TYPE OF MENTAL HEALTH PROFESSIONAL  
DOCUMENTING ALCOHOL AND DRUG COUNSELING WORK EXPERIENCE**

<b>Name of Applicant:</b>		
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Applicants Job Title:</b>		<b>Telephone #:</b>
<i><b>The following section is to be completed by employer or supervisor only</b></i>		
<b>Name of Agency:</b>		
<b>Dates of Employment:</b>  <b>From:</b> _____ <b>To:</b> _____  <b>From:</b> _____ <b>To:</b> _____		
<b>Number of hours of alcohol and drug counseling work experience:</b>		
<b>I, the employer or supervisor, of the above named applicant is certifying the information provided on this form is verifiable, factual and accurate.</b>		
<b>Signature:</b> _____ <b>Date:</b> _____		

**TO SUPERVISOR COMPLETING THIS FORM:**

**THIS FORM IS TO BE RETURNED DIRECTLY TO THE APPLICANT NOT TO THE  
BOARD OF ALCOHOL AND DRUG COUNSELORS**

## **VERIFICATION OF LICENSURE**

**To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print.** (This form may be copied as necessary)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(state) (zip code) Date of Birth: \_\_\_\_\_

License #: \_\_\_\_\_ Date Issued: \_\_\_\_\_

I hereby authorize the Licensing Authority of the State of \_\_\_\_\_ to furnish to the Maine State Board of Alcohol and Drug Counselors the information requested below.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by the State Licensing Board or Credentialing Agency verifying the above information. Please complete this section and return to the applicants address above:**

**LICENSING BOARD OR AGENCY:** This is to certify that the above-named individual was issued License or License/Credential# \_\_\_\_\_ to practice as a \_\_\_\_\_ on: \_\_\_\_\_

(date issued) \_\_\_\_\_ (expiration date) \_\_\_\_\_

**Basis of Licensure:**

- ☐ Examination: Indicate the year examination taken and by what State Licensing Board or Credentialing Agency.
- ☐ Grandfathering: Provide documentation of licensure/credentialing requirements at time of initial issuance
- ☐ ICRC Written Examination: \_\_\_\_\_ ☐ CPM Oral: \_\_\_\_\_
- ☐ State Exam \_\_\_\_\_ ☐ CCS Written Examination: \_\_\_\_\_
- ☐ Other \_\_\_\_\_
- ☐ Endorsement from \_\_\_\_\_ (Indicate state)
- ☐ Waiver - Indicate on what basis: \_\_\_\_\_

**Status of License:**    ☐Active    ☐Inactive    ☐Lapsed    ☐Other:\_\_\_\_\_

Date license expires/d:\_\_\_\_\_

**Disciplinary Action:** Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way? ☐ Yes ☐ No

If yes, please attach a copy of the decision.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

State: \_\_\_\_\_

Date: \_\_\_\_\_

(SEAL)



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GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
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04333-0035

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DIRECTOR



**AUTHORIZATION OF CREDIT CARD PAYMENT**

**Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.**

<b>Name:</b> (applicant fees being paid for)		
<b>Mailing Address:</b> (applicant fees being paid for)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>		<b>Telephone:</b>
<b>Name of cardholder:</b> (if other than applicant)		
<b>Mailing Address:</b> (if other than applicant)		
<b>City:</b>	<b>State:</b>	<b>Zip Code</b> :

**I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:**

☐ Visa ☐ MasterCard \_\_\_\_\_

Card number

Expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_ in the amount of: \$ \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PHONE: (207)624-8689  
(Office Phone)



PRINTED ON RECYCLED PAPER

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